

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0034793</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Collinsville Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>614 North Summit</u> <u>Collinsville</u> <u>62034</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Madison</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>618-344-8476</u> Fax # <u>344-8483</u>		(Type or Print Name) <u>Mike Myler</u>	
IDPA ID Number: <u>37-1239865001</u>		(Title) <u>Administator</u>	
Date of Initial License for Current Owners: <u>12/15/88</u>		(Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) <u>David C Read Jr</u> <u>Consultant</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) _____ (Telephone) <u>618-234-2273</u> Fax # <u>618-234-7777</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Date) _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Mike Myler</u> Telephone Number: <u>618-344-8476</u> Please send copies of desk review and audit adjustments to address on this page			

Facility Name & ID Number Collinsville Care Center# 0034793 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>122</u>	Skilled (SNF)	<u>115</u>	<u>42,192</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>122</u>	TOTALS	<u>115</u>	<u>42,192</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,078</u>	<u>62</u>	<u>1,633</u>	<u>2,773</u>	8
9	SNF/PED					9
10	ICF	<u>24,563</u>	<u>8,806</u>		<u>33,369</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,641</u>	<u>8,868</u>	<u>1,633</u>	<u>36,142</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.66%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/15/88

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 12/15/88NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 11and days of care provided 1,427Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐NO ☐Tax Year: 12/31/03Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Collinsville Care Center

0034793

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	150,530	11,795	5,544	167,869		167,869		167,869		1
2	Food Purchase		151,376		151,376		151,376		151,376		2
3	Housekeeping	74,073	16,484		90,557		90,557		90,557		3
4	Laundry	53,496	11,570	19,644	84,710		84,710		84,710		4
5	Heat and Other Utilities			62,271	62,271		62,271		62,271		5
6	Maintenance	40,041	15,415	37,798	93,254		93,254		93,254		6
7	Other (specify):*										7
8	TOTAL General Services	318,140	206,640	125,257	650,037		650,037		650,037		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,337,651	118,044	67,773	1,523,468		1,523,468		1,523,468		10
10a	Therapy			80,928	80,928		80,928		80,928		10a
11	Activities	41,313	7,021		48,334		48,334		48,334		11
12	Social Services	17,155			17,155		17,155		17,155		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,396,119	125,065	160,701	1,681,885		1,681,885		1,681,885		16
	C. General Administration										
17	Administrative	48,660			48,660		48,660		48,660		17
18	Directors Fees										18
19	Professional Services			6,721	6,721		6,721		6,721		19
20	Dues, Fees, Subscriptions & Promotions			31,860	31,860		31,860	(18,631)	13,229		20
21	Clerical & General Office Expenses	129,810	8,010	30,448	168,268		168,268		168,268		21
22	Employee Benefits & Payroll Taxes			279,591	279,591		279,591		279,591		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,643	3,643		3,643		3,643		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			105,178	105,178		105,178		105,178		26
27	Other (specify):*			4,212	4,212		4,212	(4,212)			27
28	TOTAL General Administration	178,470	8,010	461,653	648,133		648,133	(22,843)	625,290		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,892,729	339,715	747,611	2,980,055		2,980,055	(22,843)	2,957,212		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustment attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			105,470	105,470		105,470		105,470			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,817	96,817		96,817		96,817			32
33	Real Estate Taxes			61,644	61,644		61,644		61,644			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,830	6,830		6,830		6,830			35
36	Other (specify):*											36
37	TOTAL Ownership			270,761	270,761		270,761		270,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,861	970	10,831		10,831		10,831			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				63,285		63,285		63,285			42
43	Other (specify):* Nonallowable Costs											43
44	TOTAL Special Cost Centers		9,861	970	74,116		74,116		74,116			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,892,729	349,576	1,019,342	3,324,932		3,324,932	(22,843)	3,302,089			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,747)	27		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(2,465)	27		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(18,356)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule Chamber of Commerce	(275)	20		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,843)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (22,843)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Collinsville Care Center

ID# 0034793

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

See Accountants' Compilation Report

Summary A

12/31/03

12/31/03

[illegible]

Summary B

12/31/03

[illegible]

Facility Name & ID Number Collinsville Care Center

0034793

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mike R. Riley	33.33%	Columbia Convalescent Center	Columbia			
Steven D. Brant	33.33%	Columbia Convalescent Center	Columbia			
		Four Fountains Convalescent Center	Belleville			
John R. Snyder	33.33%	Snyder's Vaughn Haven	Rushville			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mike Riley	Director/Owner	Administrative	33.33	A	20	33.33		\$		1
2	Steve Brant	Director/Owner	Administrative	33.33	B	20	33.33				2
3	John Snyder	Director/Owner	Administrative	33.33	C	20	33.33				3
4											4
5											5
6											6
7											7
8		A- Columbia Conv Ctr	59388								8
9		B- Four Fountains	63237								9
10		- Columbia Conv Ctr	38489								10
11		C- Snyders Vaughn	69000								11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Collinsville Care Center# 0034793

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Collinsville Care Center# 0034793

Report Period Beginning:

01/01/03

Ending:

12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Union Planters		X	Mortgage	\$7,927.82	3/14/94	\$ 1,852,758	\$ 1,503,823	09/25/2004	4.5000	\$ 70,618	1	
2	Union Planters		X	Improvement Loan	\$5,800.00	4/3/96	400,000	78,052	9/25/2004	4.5000	5,074	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Union Planters		X	Revolving Line of Credit	interest only	7/13/98	500,000	423,007	9/25/2004	4.5000	21,125	6	
7												7	
8												8	
9	TOTAL Facility Related				\$13,727.82		\$ 2,752,758	\$ 2,004,882			\$ 96,817	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,752,758	\$ 2,004,882			\$ 96,817	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Collinsville Care Center**# **0034793** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																
1. Real Estate Tax accrual used on 2002 report.		\$ 42,849	1																													
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	\$ 52,247	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ 9,398	3																													
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 52,246	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 61,644	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1998</td><td>42,262</td><td>8</td></tr> <tr><td>1999</td><td>43,786</td><td>9</td></tr> <tr><td>2000</td><td>44,697</td><td>10</td></tr> <tr><td>2001</td><td>50,435</td><td>11</td></tr> <tr><td>2002</td><td>52,247</td><td>12</td></tr> </table>	1998	42,262	8	1999	43,786	9	2000	44,697	10	2001	50,435	11	2002	52,247	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2002 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1998	42,262	8																														
1999	43,786	9																														
2000	44,697	10																														
2001	50,435	11																														
2002	52,247	12																														
FOR OHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Collinsville Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0034793

CONTACT PERSON REGARDING THIS REPORT Mike Myler

TELEPHONE 618-344-8476 FAX #: 618-344-8483

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-2-21-28-18-303-001</u>	<u>Nursing Home Johnson Addition</u>	\$ <u>49,381.30</u>	\$ <u>49,381.30</u>
2. <u>13-2-21-28-18-303-003</u>	<u>Nursing Home Johnson Addition</u>	\$ <u>1,087.78</u>	\$ <u>1,087.78</u>
3. <u>13-2-21-28-18-303-002</u>	<u>Nursing Home Johnson Addition</u>	\$ <u>1,286.72</u>	\$ <u>1,286.72</u>
4. <u>13-1-21-28-18-301-034.002</u>	<u>Nursing Home Johnson Addition</u>	\$ <u>370.23</u>	\$ <u>370.23</u>
5. <u>13-2-21-28-18-303-004</u>	<u>Nursing Home Johnson Addition</u>	\$ <u>120.24</u>	\$ <u>120.24</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>52,246.27</u>	\$ <u>52,246.27</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

See Accountants' Compilation Report

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,350
 B. General Construction Type:
 Exterior Brick
 Frame Steel
 Number of Stories 1

C. Does the Operating Entity?
 [X] (a) Own the Facility
 [] (b) Rent from a Related Organization.
 [] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 [X] (a) Own the Equipment
 [] (b) Rent equipment from a Related Organization.
 [] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 [] YES
 [X] NO
 If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:
 3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	349,000	1988	\$ 77,000	1
2	Resident Care	42,343	1993-1995	13,500	2
3	TOTALS	391,343		\$ 90,500	3

STATE OF ILLINOIS

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Facility Name & ID Number Collinsville Care Center

0034793

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	122	1988	1962	\$ 1,405,000	\$ 51,091	27.5	\$ 51,091		\$ 768,478
5									
6									
7									
8									
Improvement Type**									
9	Building Improvements	1989		4,950	180	27.5	180		2,528
10	Building Improvements	1990		174,944	6,736	15-30	6,736		91,630
11	Building Improvements	1991		6,022	219	30	219		2,683
12	Building Improvements	1992		107,436	3,907	30	3,907		44,958
13	Building Improvements	1993		70,752	846	30	846		56,328
14	Storage Building	1993		45,072	1,639	27.5	1,639		16,390
15	Building Improvements	1994		15,517	388	30	388		3,727
16	Archway	1994		8,139		10			8,139
17	Storage Building	1995		77,122	1,977	30	1,977		17,463
18	Building Improvements	1995		38,417	960	30	960		8,347
19	Land Improvements	1995		6,883	459	15	459		3,901
20	Sewer Line Replacement	1996		11,224	748	10	748		5,610
21	Circulating Pumps- Heating System	1996		2,507	64	39	64		482
22	Painting,Wallpaper&Wood Refinishing for Patient Room	1996		35,405	908	39	908		6,806
23	Lens for Light Fixture	1996		567	15	39	15		109
24	Exhaust Fan & through the wall heating/AC unit	1996		3,996	102	39	102		768
25	Cement parking curbs	1996		1,928	49	39	49		370
26	Wall to Wall Carpet	1996		595	15	39	15		114
27	Resident room flooring	1996		14,000	320	39	320		2,652
28	Wall protector	1996		384	10	39	10		74
29	Hot water heater	1996		2,270	58	39	58		436
30	Flooring, boiler,painting,parking lot	1997		27,408	686	39	686		4,551
31	Walk in Cooler	1995		19,303		10			19,303
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Landscaping	1998	\$ 7,615	\$ 508	10	\$ 508	\$	\$ 2,794		37
38	Improvements	1998	1,800	45	10	45		252		38
39	Boiler & Pipes	1998	15,209	380	10	380		2,135		39
40	Airconditioners	1998	20,841	521	10	521		2,924		40
41	Comm Sys,handrails,signage,boiler	1999	31,379	784	39	784		3,598		41
42	Drain lines,flooring,fire wall	2000	24,323	608	39	608		2,168		42
43	Exterior renovation	2001	14,366	359	39	359		911		43
44	Landscaping	2002	1,250	83	15	83		125		44
45	Expansion tank, main panel,backdoor,boiler	2002	3,862	97	39	97		147		45
46	Roof	2002	23,583	590	39	590		640		46
47	Fire Alarm & sprinkler upgrades	2003	13,895	193	39	193		193		47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,237,964	\$ 75,545		\$ 75,545	\$	\$ 1,081,734		70

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 256,479	\$ 25,366	\$ 25,366	\$		\$ 217,007	71
72	Current Year Purchases	31,916	4,559	4,559		7	4,559	72
73	Fully Depreciated Assets	287,006					287,006	73
74								74
75	TOTALS	\$ 575,401	\$ 29,925	\$ 29,925	\$		\$ 508,572	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van sold in 2003			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,903,865	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,470	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,470	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,590,306	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	New wing	\$ 124,690	92
93			93
94			94
95		\$ 124,690	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 6,830 Description: Office 5511 Dietary 1319

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2004 \$ _____

13. _____/2005 \$ _____

14. _____/2006 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
					Units	Cost									
1	Licensed Occupational Therapist	10-3	hrs	\$		401	\$ 24,268	\$	401	\$ 24,268	1				
2	Licensed Speech and Language Development Therapist	10-3	hrs			75	6,433		75	6,433	2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist	10-3	hrs			880	50,227		880	50,227	4				
5	Physician Care		visits								5				
6	Dental Care		visits								6				
7	Work Related Program		hrs								7				
8	Habilitation		hrs								8				
9	Pharmacy	39-2	# of prescripts					9,861		9,861	9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10				
11	Academic Education		hrs								11				
12	Exceptional Care Program										12				
13	Other (specify):										13				
14	TOTAL			\$		1,356	\$ 80,928	\$ 9,861	1,356	\$ 90,789	14				

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Collinsville Care Center

Provider #: 0034793

01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 20,595	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	569,274		3
4	Supply Inventory (priced at cost)	21,736		4
5	Short-Term Investments			5
6	Prepaid Insurance	163,047		6
7	Other Prepaid Expenses	252		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 774,904	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	2,336		11
12	Long-Term Investments			12
13	Land	90,500		13
14	Buildings, at Historical Cost	2,343,347		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	594,703		16
17	Accumulated Depreciation (book methods)	(1,590,307)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): goodwill	1,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,441,579	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,216,483	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 305,764	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	423,007		29
30	Accrued Salaries Payable	77,071		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,246		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 858,088	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	78,052		39
40	Mortgage Payable	1,503,824		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,581,876	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,439,964	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (223,481)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,216,483	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (213,579)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (213,579)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(9,901)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (9,902)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (223,481)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Collinsville Care Center

0034793

Report Period Beginning: 01/01/03

Ending:

12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,318,774	1
2	Discounts and Allowances for all Levels	(149,850)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,168,924	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,810	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 55,810	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,162	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	69,647	17
18	Sale of Supplies to Non-Patients	13,029	18
19	Laboratory		19
20	Radiology and X-Ray	1,876	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 85,713	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	4,584	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,584	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,315,031	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	650,037	31
32	Health Care	1,681,885	32
33	General Administration	648,133	33
	B. Capital Expense		
34	Ownership	270,761	34
	C. Ancillary Expense		
35	Special Cost Centers	10,831	35
36	Provider Participation Fee	63,285	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,324,932	40
41	Income before Income Taxes (line 30 minus line 40)**	(9,901)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (9,901)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. return on extension

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Collinsville Care Center

0034793

Report Period Beginning: 01/01/03

Ending:

12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,160	2,160	\$ 48,635	\$ 22.52	1
2	Assistant Director of Nursing	2,160	2,160	43,543	20.16	2
3	Registered Nurses	10,637	10,995	266,302	24.22	3
4	Licensed Practical Nurses	13,468	14,302	232,278	16.24	4
5	Nurse Aides & Orderlies	68,026	70,186	727,060	10.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,950	1,950	19,833	10.17	8
9	Activity Director	1,905	1,985	18,992	9.57	9
10	Activity Assistants	2,448	2,448	22,321	9.12	10
11	Social Service Workers	1,215	1,295	17,155	13.25	11
12	Dietician					12
13	Food Service Supervisor	2,160	2,160	31,879	14.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,235	13,835	118,651	8.58	15
16	Dishwashers					16
17	Maintenance Workers	3,674	3,834	40,041	10.44	17
18	Housekeepers	8,623	9,802	74,073	7.56	18
19	Laundry	7,402	7,642	53,496	7.00	19
20	Administrator	2,160	2,160	48,660	22.53	20
21	Assistant Administrator					21
22	Other Administrative	1,560	1,572	39,877	25.37	22
23	Office Manager					23
24	Clerical	5,943	6,063	89,933	14.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,726	154,549	\$ 1,892,729 *	\$ 12.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	163	\$ 4,309	1-3	35
36	Medical Director	48	7,200	9-3	36
37	Medical Records Consultant	20	745	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	840	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Asst Med Dir	48	4,800	9-3	47
48					48
49	TOTAL (lines 35 - 48)	327	\$ 17,894		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 494	10-3	50
51	Licensed Practical Nurses	768	24,262	10-3	51
52	Nurse Aides	2,018	38,305	10-3	52
53	TOTAL (lines 50 - 52)	2,802	\$ 63,061		53

Facility Name & ID Number **Collinsville Care Center**

XIX. SUPPORT SCHEDULES

STATE OF ILLINOIS

0034793

Page 21

Report Period Beginning: **01/01/03** Ending: **12/31/03**

<p>A. Administrative Salaries</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 10%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Alice Green</td> <td>Administrator</td> <td>0</td> <td style="text-align: right;">\$ 48,660</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 48,660</td> </tr> </tbody> </table> <p>B. 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* Attach copy of IMRF notifications

**See instructions.

Collinsville Care Center
Provider #: 0034793
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	6,721
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Allocated from Management Company

Total (agree to Schedule V, line 19, column 8)	<u>6,721</u>
---	---------------------

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 63,285
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n?A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Collinsville Care Center

11:30 AM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-22,843	equal to	-22,843	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	96,817	equal to	96,817	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	61,644	equal to	61,644	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	105,470	equal to	105,470	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,830	equal to	6,830	0	O.K.	Pg14 J30+N40	B. + C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	80,928	equal to	80,928	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	9,861	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	650,037	equal to	650,037	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,681,885	equal to	1,681,885	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	648,133	equal to	648,133	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	270,761	equal to	270,761	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	10,831	equal to	10,831	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	63,285	equal to	63,285	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,317,818	equal to	1,337,651	-19,833	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	41,313	equal to	41,313	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,155	equal to	17,155	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	150,530	equal to	150,530	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	40,041	equal to	40,041	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	74,073	equal to	74,073	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	53,496	equal to	53,496	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	88,537	equal to	48,660	39,877	FAILED	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	89,933	equal to	129,810	-39,877	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,892,729	equal to	1,892,729	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	4,309	< or = to	5,544	-1,235	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,200	< or = to	12,000	-4,800	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	64,646	< or = to	67,773	-3,127	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	48,660	equal to	48,660	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	6,721	equal to	6,721	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	279,591	equal to	279,591	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	13,229	equal to	13,229	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,643	equal to	3,643	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	63,285	equal to		0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,427	equal to	1,633	-206	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	2,004,882	equal to	0	2,004,882	FAILED	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	52,246	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	90,500	equal to		0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,237,964	equal to	0	2,237,964	FAILED	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	575,401	equal to		0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,590,306	equal to	#VALUE!	#VALUE!	#VALUE!	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-223,481	equal to	-223,481	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-9,901	equal to	-9,901	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,216,483	equal to	2,216,483	0	FAILED	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter One Center Expenses	You must check the SUPPORT CASE. That's done TO THE SUPPORT CENTER			11/30/2008
File number	Name	Address	Phone	Case Number
Cost report period	From	to	to	Base Number
Enter an 8-22-02 facility, enter a 1 or 02	62-102	01/01/02	36-102	90.00%
Current last day				
Current Date of Support/Case	0			
Card Services Salary/Wage	318,160 (Card 1, Line 8 - (check))			
Card Admin Salary/Wage	176,475 (Card 2, Line 28 - (check))			
Total Salary/Wage	1,660,738 (Card 1, Line 46 - (check))			
Employee Benefits	276,801 (Card 2, Line 32 - (check))			
Total Personnel	693,037 (Card 8, Line 9 - (check))			
Total General Admin	639,200 (Card 2, Line 28 - (check))			

[illegible]

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W	SupportRate percent
2	37.53
3	54.56
4	37.53
5	32.69
6	43.80
7	43.80
8	43.80
9	36.02
10	40.04
11	36.83

	2006	700n	300n
Category	SupportRate	SupportRate	SupportRate
0000	2	33.3%	26.6%
0001	3	32.7%	26.6%
0002	4	33.3%	26.6%
0003	6	30.4%	23.7%
0700	6	40.4%	31.6%
0701	7	40.4%	31.6%
0702	8	40.4%	31.6%
0703	9	37.6%	28.3%
0704	10	36.6%	27.6%
0005	11	32.7%	26.6%

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23 Provider Participation fee is linked from page 4